

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 010887	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 10/09/2015
NAME OF PROVIDER OR SUPPLIER BROOKDALE MERRILLVILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 8253 VIRGINIA ST MERRILLVILLE, IN 46410		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{R 000}	<p>INITIAL COMMENTS</p> <p>This visit was for a Post Survey Revisit to the State Residential Licensure Survey completed on August 25, 2015.</p> <p>Survey date: October 9, 2015</p> <p>Facility number: 010887 Provider number: 01887 AIM number: N/A</p> <p>Census bed type: Residential: 27 Total: 27</p> <p>Sample: 7</p> <p>Brookdale Merrillville was found to be in compliance with 410 IAC 16.2-5 in regard to the PSR to the State Residential Survey.</p> <p>Quality review completed by 26143, on October 13, 2015.</p>	{R 000}		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE